



Prosecutions

£280,000 Fine after Worker is Crushed

A worker who had only been on site for two weeks was killed when his head was crushed between concrete blocks and a metal platform.

The Health and Safety Executive (HSE) has prosecuted brick manufacturing company Hanson Building Products Ltd, after the death of Peter Clarke, 57, at the company's distribution plant in Coleshill on 26 April 2008. The company was fined £280,000 and ordered to pay costs of £29,204.

Warwick Crown Court heard that Mr Clarke, from Bedworth, was working next to a conveyor that transferred groups of concrete blocks from a kiln to a packaging area. His job was to remove samples of blocks for quality checking.

Sections of blocks were formed into larger groups for packaging by moving the conveyor's direction of travel backwards and forwards.

Mr Clarke was standing next to a low bridge over the conveyor when he leaned forward to remove some blocks from the machine. Another worker changed the direction of the conveyor, crushing Mr Clarke's head between the concrete blocks on the conveyor and the metal platform.

The operator of the 30-metre conveyor could not see Mr Clarke because his view was obscured.

An HSE investigation into the incident found that the company had only identified the risk of workers trapping their fingers between the blocks and the stairway.

HSE inspector Peter Snelgrove said: "This tragic incident could have been prevented if Hanson Building Products had carried out a suitable and sufficient risk assessment to identify all the hazards for workers operating in this area.

"There were no safe systems of work for removing the blocks and the company failed to supervise Mr Clarke adequately. The area where he was working was well known as a danger zone by other workers, but he had been on site for less than two weeks and nobody had told him about the risks.

"Employers should understand that where failing standards in the workplace result in serious injury or death, HSE will prosecute."

Mr Clarke's widow, Barbara, said: "Pete's death has devastated our family and for him to have lost his life due to a work-related incident is beyond belief.

"He was a much-loved husband, father and grandpa and our lives will never be the same without him.

"I would like to thank Peter Snelgrove from HSE for his help and the sensitive way in which he has dealt with us during this difficult time."

Hanson Building Products Limited, whose headquarters is at Castle Hill, Maidenhead, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974.



News

Workplace Fatalities Fall

New figures released by the HSE reveal that the number of people killed at work in Britain fell last year to a record low.

The HSE has released the provisional data, which shows that 151 workers were killed between 1 April 2009 and 31 March 2010 compared to 178 deaths in the previous year and an average number over the last 5 years of 220 deaths per year.

Despite the overall improvement, agriculture, the most dangerous industry in Britain, has recorded a sizeable increase in deaths; 38 workers died on farms in the last year, marking a disappointing return to levels of earlier years after a record low of 25 deaths in 2008/09.

Large falls have been recorded in some of the other historically most dangerous industries in Britain:

- 41 fatal injuries to construction workers were recorded - a rate of 2.0 deaths per 100,000 workers, compared to an average of 66 deaths in the past five years and a fall from the 52 deaths (and rate of 2.4) recorded in 2008/09
- 42 fatal injuries to services workers were recorded, a rate of 0.2 deaths per 100,000, compared to an average of 72 deaths in the past five years and a fall from the 62 deaths (and rate of 0.3) recorded in 2008/09
- 24 fatal injuries to manufacturing workers were recorded, a rate of 0.9 deaths per 100,000, compared to an average of 38 deaths in the past five years and a fall from 33 deaths (and rate of 1.1) in 2008/09.

Other factors of note:

- Eurostat have made a comparison of the fatal injury rates across EU countries. This reveals that the fatal injury rate for Great Britain is consistently one of the lowest in Europe
- there were 70 members of the public fatally injured in accidents connected to work in 2009/10 (excluding railways-related incidents).

Judith Hackitt, the HSE Chair said:

"It's really very encouraging to see a further reduction in workplace fatalities in the past year. This is performance which owes much to good practice, leadership and employee engagement. No doubt the recession has resulted in lower levels of activity in some sectors and a decrease in the numbers of new inexperienced recruits has also contributed to this fall in fatalities.

"We should also remember that 151 families are mourning the loss of someone who last year went out to work and never came home. Being one of the best health and safety performers in the world means continuing to strive to drive these numbers down further - not getting complacent about what we've collectively achieved and recognising the new challenges as we emerge from the recession."

Judith Hackitt added:

"We are especially concerned to see the continuing high levels of fatalities in agriculture.

"The fact that many of these lives have been lost in family businesses is a double tragedy. Not only have families been ripped apart, but businesses that have been handed down through generations have been ruined.



"No industry can or should regard high levels of workplace death and injury as being 'part of the job'. It doesn't have to be this way as many other sectors have shown by their improvement."

Child Killed in Gate Incident

A six-year-old girl has died after becoming trapped in an electronic gate in Manchester.

Emergency services were called to the entrance to flats off Maine Road in Moss Side last Monday (28 June 2010).

Semelia Campbell was caught between the rolling gate and a brick post, a police spokesman said. A police officer smashed the motor on the gate to stop it closing further and pulled her out, he added. She was taken to hospital but died soon afterwards.

Greater Manchester Police has started a joint inquiry with the Health and Safety Executive (HSE).

As the site is still under construction and the gate was in a communal area, the HSE must investigate the incident, a spokeswoman said.

New Powers to Tackle Dangerous Vehicles

Proposals set out in a consultation document from the Department for Transport would give the Vehicle and Operator Services Agency (VOSA) more flexibility in tackling vehicles they suspect of being overloaded or breaking operating or driving hours rules.

The new powers would also help VOSA to enforce new cabotage rules, which govern the amount of UK domestic work hauliers from outside the UK can undertake.

The consultation also outlines plans to give VOSA officers in Scotland the power to independently stop commercial vehicles for the first time. Currently, all VOSA enforcement in Scotland is assisted by the police.

Currently, VOSA inspectors can only independently stop drivers if they suspect there is a fault with the vehicle – although they can and do then check for other offences. These new plans would extend VOSA's powers and allow their inspectors – without the need for police assistance – to pull drivers over to check that they are complying with rules on maximum weight limits, driving hours, operator licensing and cabotage.

The planned changes will also include new measures to allow the VOSA Chief Executive to authorise inspectors to stop vehicles rather than needing to get accreditation from individual police forces.

Worker Killed in Refinery Fire and Explosion

A worker has been found dead after a fire and explosion at an oil refinery in North East Lincolnshire.

The man was working near a crude oil distillation unit which exploded at Lindsey Oil Refinery in North Killingholme last Tuesday (29 June 2010).

Two other people suffered minor injuries in the incident.

More than 50 firefighters from Humberside Fire and Rescue Service were called to the plant where black smoke was seen billowing into the sky.

Oil company Total, which runs the refinery, said that formal investigations were being carried out by the police and the Health and Safety Executive.



"We are fully co-operating with these inquiries in order to understand exactly why this tragic incident occurred," it added.

People living near the plant reported hearing the explosion. Employees at the refinery said the fire started in a superheated industrial heater near where they walked to work.

The parts of the refinery affected by the explosion have been shut down and safely isolated, Total said.

Substances Added to Concern List

The European Chemicals Agency has added eight chemical substances to the Candidate List of Substances of Very High Concern (SVHC) for authorisation.

The Agency advise companies to check their potential obligations that result from this listing.

Following the unanimous agreement of the Member State Committee, ECHA is adding the eight substances on the Candidate List, which now contains 38 substances in total. The eight substances, which are carcinogenic, mutagenic or reprotoxic (CMR) substances, are listed below. As foreseen by REACH, a specific procedure will be followed to decide whether the substances should also be included in the authorisation list.

Companies may have legal obligations resulting from the inclusion of substances in the List. These obligations can apply to the listed substances on their own as well as in mixtures and in articles.

The eight substances are as follows:

- Trichloroethylene
- Boric acid
- Disodium tetraborate, anhydrous
- Tetraboron disodium heptaoxide, hydrate
- Sodium chromate
- Potassium chromate
- Ammonium dichromate
- Potassium dichromate.

Guidance

Effective Fire Safety in the Design, Management and Use of Buildings

BS 9999 is the key standard for fire safety in buildings. This new guide, issued by the BSI, delivers the tools needed to use the standard effectively, plus sets out a methodology for successfully deploying its flexible design recommendations.

Bringing together the key information on BS 9999, including learning points and background information, the handbook can help to effectively prepare or evaluate designs to the requirements of the Building Regulations.

It covers:

- risk profiles including occupancy characteristics
- management levels
- additional fire protection measures
- travel distances, door and stair widths
- escape for disabled people
- considerations for fire fighting



- building structure
- theatres and cinemas
- shopping complexes
- plant buildings and outdoor structures.

Worked examples are included to stress the considerations required for a two-storey retail unit, a high-rise office building, and a mixed-risk profile building.

Management of GDA Outcomes

The Generic Design Assessment (GDA) process has been set up to improve clarity and certainty in the new nuclear power station regulatory process. It provides a structured process for early engagement between reactor designers and regulators, with the HSE and Environment Agency working together. It allows safety cases for the generic new reactor designs to be assessed well ahead of any construction in the UK, and for safety issues to be identified and resolved early in the project. GDA also allows the possibility of using a generic safety case as the basis for the regulation of a fleet of reactors, based on a common design.

This guidance document sets out the process for managing the outcomes from the GDA, and outlines the process for taking those outcomes into the ongoing design, procurement, construction and commissioning phases of specific power stations. It also outlines the arrangements that will be applied by regulators for management of the end of the GDA process.

The guidance has been developed from the principles set out in the earlier GDA guidance documents and further discussions with stakeholders in the light of experience of assessment to-date. It also builds on and reflects upon comments received on the initial discussion document on the management of GDA Design Acceptance Confirmations that was published in May 2009. It is aimed at providing advice to GDA Requesting Parties (RPs), potential future operators and other stakeholders. It also provides the general public with transparency about how the end of GDA will be managed.

This guidance caters for a variety of potential outcomes from the GDA including the possibilities that a meaningful assessment cannot be completed, or that regulators cannot conclude in favour of the proposed designs.

A meaningful GDA will be one where:

- the regulators have received sufficient information on the generic reactor design in the safety, security and environment submissions to allow assessment in all relevant technical topic areas; and
- the regulators have completed a sufficiently thorough and detailed assessment of the information in the generic safety, security and environment submissions.

Reports

Director Leadership of Health and Safety

This is the report of the HSE Chief Scientist-led Steering Group asked to oversee an independent evaluation of measures taken to strengthen director leadership of health and safety.

The Steering Group commissioned and considered five new items of evidence to inform an assessment of the impact of the joint HSE-IoD guidance on director leadership on health and safety. Those most directly relevant were two surveys of directors: one between July-September 2008, around nine months after publication of the guidance, and a second, a follow-up survey between September-November 2009. The HSE-IoD guidance is aimed at organisations with five or more employees, and as such, organisations below this size were excluded from the surveys.

In summary, the evidence reviewed by the Steering Group suggests that:

- the numbers of organisations in which directors were aware of the guidance, had read it and subsequently taken action were significantly higher in autumn 2009 than in autumn 2008
- the transition from awareness to readership and subsequent action was broadly the same in the two surveys. For example, in the baseline study, about 1 in 4 directors was aware of the guidance. About half of the directors who were aware of the guidance read all or parts of it. Again about half (48%) took some action after reading (some or all of) the document. This means that in the baseline study about 6% of all directors said they had taken some action after reading the guidance. It is not possible to ascertain a causal relationship between reading the guidance and taking action
- given that the interval between the two surveys coincided with publicity and media coverage of other issues relevant to director responsibilities for health and safety, it is not possible to link any of the changes observed to the issuing of the guidance specifically.

Director Leadership Behaviour Research

In October 2007, the HSE and Institute of Directors (IoD) jointly published guidance for directors encouraging them to lead on health and safety in their organisations; the publication was entitled 'Leading Health and Safety at Work: leadership actions for directors and board members' (INDG417).

Following the completion of a baseline study to assess awareness and impact of the guidance among directors/board members, the HSE commissioned qualitative research to explore:

- what directors/board members understand about the current legislative framework for health and safety
- what directors/board members mean when they say they have taken action in the areas covered in the baseline study
- whether and how board level actions translate into action on the 'shop floor' and genuine improvements in health and safety
- the impact of board level behaviour change from the perspective of health and safety managers
- whether there are opportunities to influence behaviour.

The research was conducted through qualitative face to face interviews with directors, health and safety managers and shop floor respondents from 30 organisations interviewed in the baseline study.

The key conclusions of this study are:

- the study showed that directors have a broad understanding that they are liable for health and safety failures and consequently they treat it as a serious issue, particularly in large high risk organisations where health and safety is an integral part of their activities
- recent changes in legislation have led directors to check compliance but have not had a major impact on their day to day activities as most feel they are already compliant
- adherence to regulations was not the main motivator for having good health and safety practice
- most directors were inclined to focus on safety risks rather than health risks
- what directors mean where they say they have implemented a behaviour varies considerably
- the impact of directors' behaviour is difficult to measure but it does make a difference to staff to feel that directors care about their wellbeing.

The Great Britain Asbestos Survey 1971-2005

The aim of the report was to describe the frequency of asbestosis and mesothelioma among participants of the GB Asbestos Survey, and to identify factors associated with the risk of death with these diseases.

Among the 98,912 survey participants included in the analysis, there were 15,557 deaths between 1971 and 2005. Altogether 477 asbestosis and 649 mesothelioma deaths were identified on the Asbestosis and



Mesothelioma Registers respectively. The underlying cause of death was asbestosis for 116 (24%) of the asbestosis cases, and mesothelioma for 398 (64%) of the mesothelioma cases on the registers.

The report notes:

- asbestos workers had significantly higher mortality than the GB population; the standardised mortality ratio for all causes of death was 142 (95% CI 139-144)
- the risk of asbestosis or mesothelioma was lower in later birth cohorts
- asbestosis deaths peaked in the 1980s, while deaths with mesothelioma were higher during the 1990s and 2000-2005
- the risk of asbestosis and mesothelioma rose with increasing duration of exposure, reaching a peak at 30-39 years' exposure
- the highest risk of asbestosis was observed 50 or more years after first occupational exposure to asbestos, and for mesothelioma 40-59 years after first exposure
- insulation workers, followed by stripping/removal workers, had the highest risk of asbestosis and mesothelioma, and manufacturing workers had the lowest risk. 'Other' exposed workers had intermediate levels of risk.

The GB Asbestos Survey should continue to monitor the health of the asbestos workers, in order to confirm whether the occurrence of asbestos-related diseases has decreased following the implementation of regulations to control occupational exposure to asbestos.

Chemical Hazards and Poisons Report

This issue of the Chemical Hazards and Poisons Report, issued by the Health Protection Agency, provides papers on four different types of chemical incidents. Three of these incidents are particularly pertinent to the development of a UK chemical incident recovery handbook (which was announced in the January 2010 issue).

In the first incident, the discovery of a piece of military ordnance in sand dunes at a beach in Wales and reported to the police by a concerned member of the public, resulted in the shell being disabled by Army Explosive Ordnance Disposal experts the same day; three days later, Public Health Wales was notified that two members of the disposal team were receiving hospital care for severely blistered skin. The second incident report describes the complex story of the withdrawal of pork products as a result of contaminated animal feed, resulting in a large scale incident that raised many challenging technical issues. The third paper summarises three case studies where asbestos contamination occurred in domestic, health care and education settings. Each of these events suggests the need for the development of chemical incident recovery guidance.

The report comments that, as always, emergency planning and response is key. The report also highlights four developments that are likely to enhance preparations for the London 2012 Olympics. These are:

- the work of the HPA's Real-time Syndromic Surveillance Team, which reports that the combination of syndromic surveillance systems used to routinely monitor the emergence and spread of common infectious diseases in the community in 'real-time' can also be used to provide wider health surveillance support in national incidents, including chemical and radiological emergencies
- the development by the HPA of a method for estimating excess deaths quickly in relation to heatwaves, which can be applied to other events such as coldwaves or widespread air pollution incidents
- the concept, developed by the Metropolitan Police, of a Joint Safety and Health Advice Cell, which should facilitate our ability to work together across the frontline and with other emergency responders including the NHS, to ensure the best use of safety and health expertise and resources during major incidents
- the new CHEMET Service from the Met Office, introduced in August 2009, using the Met Office's state of the art dispersion model NAME III (the Numerical Atmospheric dispersion Modelling Environment). This represents a significant advancement in the sophistication of the modelling being used and means that the Met Office now offers a seamless dispersion modelling service, ranging from a few kilometres up to



global scale events, such as volcanic eruptions from the Eyjafjallajökull volcano in Iceland.

The report also questions whether, with the Olympics approaching, are there likely to be health risks from firework displays? An article is included discussing the legislation and acute effects from fireworks.

Case Law

Newspaper Delivery Boy case goes to the Court of Appeal

On 24 September 2005, at 14.10 hrs, when delivering papers, Joshua Smith cycled across a road without looking straight into the path of a flat-bed lorry. Although the driver, Mark Hammond, braked hard and swerved sharply, he hit Joshua who was severely injured as a result.

The incident also had a severe effect on Mr. Hammond, who subsequently suffered post-traumatic stress disorder.

Joshua brought proceedings against the Co-operative Group Limited ('the Co-op'), as his employer, for failing to take proper care to prevent him from suffering personal injury in the course of his employment and against Mr. Hammond for negligent driving.

Mr. Hammond sought by way of counterclaim to recover damages from Joshua, and from the Co-op as his employer, for negligence in causing the accident which adversely affected his psychiatric health.

The Court found that the accident had been caused by Mr. Hammond's negligence, but that Joshua had been careless as well and was 60% to blame. He dismissed Mr. Hammond's counterclaim entirely because he was unable to accept that a person of Joshua's age would foresee physical injury to the driver of the lorry under those circumstances.

Mr. Hammond appealed against the judge's finding that the accident was caused by negligence on his part and against the dismissal of his counterclaim.

At the time of the accident the road was dry and the visibility good. There was little traffic and few parked vehicles. It was agreed that Mr Hammond was driving at about 30 mph.

The original hearing held Mr. Hammond liable because he had failed to sound his horn at the appropriate time, having admitted that he was aware that Joshua was not looking in the direction from which he was approaching, and accepting that he could have 'beeped' him.

Mr Hammond explained that he did not sound his horn as he did not think that Joshua would continue into the road without looking. As such, the appeal found that Mr. Hammond's answers in cross-examination did not amount to a plea of guilty to negligence.

The Court heard evidence from a Dr Searle that even if Mr. Hammond had taken steps to sound his horn the accident was already inevitable, because the overall time required for Mr. Hammond to sound the horn and for Joshua to react to it would have been about three to four seconds, by which time Joshua would already have been part way across the road and into the path of the lorry. The judge, however, rejected that evidence, preferring to rely on his own experience of reacting to the sound of a horn when driving.

The appeal found that the judge was wrong to reject Dr. Searle's evidence, and allowed Mr. Hammond's appeal on the issue of liability and set aside the judgment against him.

With regards to the counter claim, the judge found that Joshua was substantially to blame for the accident and it is inherent in that finding that he was careless both of his own safety and that of Mr. Hammond. Since, for the reasons given earlier, Mr. Hammond was not to blame for the accident, his counterclaim must succeed in full.



HEALTH & SAFETY NEWS

Issue	1
Date:	07/07/10
Page:	9 of 9

For these reasons the appeal found that the judgment against Mr. Hammond should be set aside and damages to be assessed.

At the trial the Co-op agreed that if Mr. Hammond's counterclaim were to succeed it would accept liability as Joshua's employer and would not seek to recover any part of the damages from Joshua himself.